



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE: (208) 334-6626
FAX: (208) 364-1888

February 2, 2010

Richard Davis
Boise Group Home #1 Pennfield
P.O. Box 4243
Boise, ID 83711

RE: Boise Group Home #1 Pennfield, Provider #13G017

Dear Mr. Davis:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Boise Group Home #1 Pennfield, on January 29, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
3. Identify the date each deficiency has been, or will be, corrected.
4. Sign and date the form(s) in the space provided at the bottom of the first page.

Richard Davis
February 2, 2010
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5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 16, 2010**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

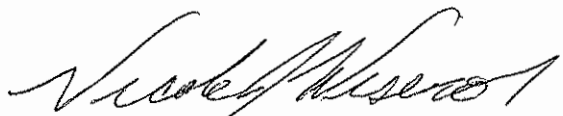
This request must be received by February 16, 2010. If a request for informal dispute resolution is received after February 16, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MONICA WILLIAMS
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MW/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/01/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2010
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NAME OF PROVIDER OR SUPPLIER

BOISE GROUP HOME #1 PENNFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE

**3855 PENNFIELD STREET
BOISE, ID 83704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	<p>INITIAL COMMENTS</p> <p>Boise Group Homes #1 - Pennfield, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.</p> <p>The survey was conducted by: Monica Williams, QMRP, Team Leader Amy Petersen, QMRP Jim Troutfetter, QMRP</p>	W 000		

RECEIVED
FEB 25 2010
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

2/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G017	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2010
NAME OF PROVIDER OR SUPPLIER BOISE GROUP HOME #1 PENNFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 3855 PENNFIELD STREET BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey. The survey was conducted by: Monica Williams, QMRP, Team Leader Amy Petersen, QMRP Jim Troutfetter, QMRP	M 000		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all chemicals were stored under lock and key for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals and the potential for misuse of them. The findings include: During an environmental survey conducted on 1/27/10 from 12:00 - 1:09 p.m., the following toxic chemicals were noted to be in an unlocked cabinet in the food storage area: - Four cans of Easy-Off oven cleaner. - One can of bug spray. - One bottle of Lime-A-Way cleaner. The Home Supervisor, who was present during the survey, was notified of the chemicals and immediately removed them and placed them in a locked cabinet in the garage. When asked during an interview on 1/29/10 from 9:07 - 10:30 a.m., the Program Director stated the chemicals should have been in a locked	MM271	The home manager is responsible for daily cleaning assignments and follow through. The manager will receive training regarding the storage of toxic chemicals, cleaning procedures and check list implementation. Responsible staff: Administrator Completion date: 3/15/10 RECEIVED FEB 17 2010 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

2/16/10

Bureau of Facility Standards

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MM271	Continued From page 1 cabinet. The facility failed to ensure all toxic chemicals were properly stored under lock and key.	MM271		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure the facility was kept clean and in good repair for 5 of 5 individuals (Individuals #1 - #5) residing in the facility. The findings include: During an environmental survey conducted on 1/27/10 from 12:00 - 1:09 p.m., the following concerns were noted: Living Room: - The ceiling had a water-damaged area that was approximately 3 inches in diameter. - The slats of 3 sets of window blinds were bent. Dining Room: - The floor vent was bent. Kitchen: - The base board to the left side of the entrance was missing. - There was baked-on grease on 4 cookie sheet pans, 2 muffin tins, 1 loaf pan, and 1 square	MM380	<i>see mm 271</i>	

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MM380	<p>Continued From page 2</p> <p>baking pan.</p> <ul style="list-style-type: none"> - Four kitchen cabinet doors were missing handles, and 1 cabinet's handle was not secured to the cabinet but was hanging down on one side. <p>Hallway:</p> <ul style="list-style-type: none"> - The ceiling air exchange vent had cobwebs and dust on it. - The utility closet door was missing one door panel. <p>Individual #1 and #2's Bedroom:</p> <ul style="list-style-type: none"> - The right closet door was missing a handle. <p>Individual #1 and #2's Bathroom:</p> <ul style="list-style-type: none"> -The toilet was missing the anchor bolt covers. -The faucet was leaking around the hot and cold handles. -The hot and cold handles had a calcium build-up and mildew under the handle covers. -The faucet had rust on it. -The light fixture had two bulbs not working. <p>Bathroom by Garage:</p> <ul style="list-style-type: none"> -The faucet was leaking around the hot and cold handles. -The hot and cold handles had a calcium build-up and mildew under the handle covers. -The faucet was missing its aerator. <p>Backyard:</p> <ul style="list-style-type: none"> -The fence was missing one slat. -The gate near the garage contained a rusted lock. When asked, the Home Supervisor, who was present, stated the lock should not be there and she would have it immediately removed. She stated no individuals eloped from the facility. 	MM380		